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Resurgence of syphilis in England

In their commentary on the resurgence of syphilis in England, Fenton *et al*[1] cover issues surrounding controlling outbreaks of syphilis, quoting parallels in the United States, and identify the need for simple treatment, preferably with a single dose regimen. Two important differences between the two countries in management strategy that could be relevant to the current UK situation are, however, not discussed. Firstly, variation in penicillin treatment regimen: in the United States single dose benzathine penicillin is recommended for primary, secondary, and early latent syphilis,[2] whereas in the United Kingdom, 10 days of procaine penicillin is the preferred regimen except when compliance is likely to be a problem.[3] Secondly, epidemiological treatment of sexual contacts is a policy pursued actively in the United States but not in the United Kingdom.[4]

These differences have evolved as responses to the epidemiological patterns of syphilis in the two countries. In the United States outbreaks of syphilis are well recognised whereas in the United Kingdom they are a relatively new phenomenon. Given the success in managing outbreaks in the United States it might be relevant to review proved aspects of syphilis management using single dose benzathine penicillin, as in the United States, that could be applied in the United Kingdom. Adopting this treatment regimen would also open the way for other effective treatment strategies such as selective mass treatment and epidemiological therapy in high prevalence populations. The issue of compliance with protracted regimens of procaine penicillin, a problem that takes up considerable time of genitourinary medicine clinic staff, would also be solved. Although concerns about using a single dose of benzathine penicillin in HIV positive subjects with advanced immunosuppression have been raised, possible treatment failures are still at the case report stage. Furthermore, there are no documented treatment failures in Africa where the prevalence of syphilis and HIV is the highest. World Health Organization currently recommends that HIV infected patients with early syphilis are treated no differently from non-HIV infected patients and recommends single dose therapy.[5]

In trying to identify new interventions to improve STI control for limiting the spread HIV, the basic principles of STI control are, if anything, more relevant today compared with the past. Although the issues and arguments raised here have been discussed in depth previously,[6] they bear repeating in the light of the recent increase in syphilis in the United Kingdom.

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Vulvovaginitis due to fluconazole resistant *Candida albicans* following self treatment with non-prescribed triazoles

Resistance of *Candida albicans* to triazoles is uncommon with short term treatment but has been increasingly reported in immunocompromised patients, including those with HIV infection who are receiving long term systemic or maintenance therapy. Vaginal triazole resistant *C albicans* isolates are extremely rare in non-immunocompromised HIV seronegative women.[1] To our knowledge, only a single case has been reported to date.[2] As over the counter oral triazole antifungals are now widely available there is potential for drug resistance to increase. We report another case of vulvovaginitis due to triazole resistant *C albicans* in an otherwise healthy woman.

The patient was a 28 year old woman who presented with symptoms of vulval pruritis and profuse vaginal discharge for six months. She was not taking regular medication but had used clotrimazole and fluconazole several times in the preceding months with no clinical improvement. On examination, the vulva looked healthy but the vagina was erythematous and white plaques were noted. The cervix appeared normal and bimanual pelvic examination was unremarkable. The patient declined HIV serology but was fit and well with no stigmata of HIV infection and no risk factors.

Microscopic examination of vaginal secretions did not reveal any yeast blastospores or pseudohyphae, nor any clue cells or trichomonads. However, *C albicans* was isolated on culture. In view of the documented history of a lack of response to topical and oral azoles, the patient was treated with nystatin pessaries daily for two weeks, while antifungal sensitivity tests were being performed. The patient returned to clinic two weeks later and reported only slight improvement in her symptoms despite using vaginal nystatin as prescribed. Unfortunately, the sensitivity test results were not available at this time and the patient subsequently failed to attend the clinic.

In vitro sensitivity testing by the Mycology Reference Laboratories (Bristol, UK) using the NCCLS M27A assay[3] revealed that the vaginal *C albicans* isolate was resistant to both fluconazole (minimum inhibitory concentration (MIC) > 64 μg/ml) and itraconazole (MIC > 16 μg/ml) but sensitive to nystatin (MIC = 2 μg/ml), miconazole (MIC < 0.125 mg/l) and clotrimazole (MIC = 0.25 mg/l).

In vitro susceptibility to antifungal agents appears to be a poor predictor of therapeutic success but in vitro resistance, defined by high MIC levels, correlates well with clinical resistance.[4 5] However, despite the lack of a clear correlation between in vitro susceptibility and clinical response such data may assist the selection of alternative antifungal agents in cases of apparent clinical resistance.

As the patient did not attend for review, we do not know whether a microbiological cure was effected by this therapy, and therefore, we cannot exclude the possibility that the patient's symptoms were due to other pathology. Nevertheless, this case indicates that the possibility of triazole resistant *C albicans* should be considered in non-immunocompromised individuals with refractory vulvovaginal symptoms and a history of self medication.

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